

## What is the *Partnership Program*?

### PROGRAM GOALS

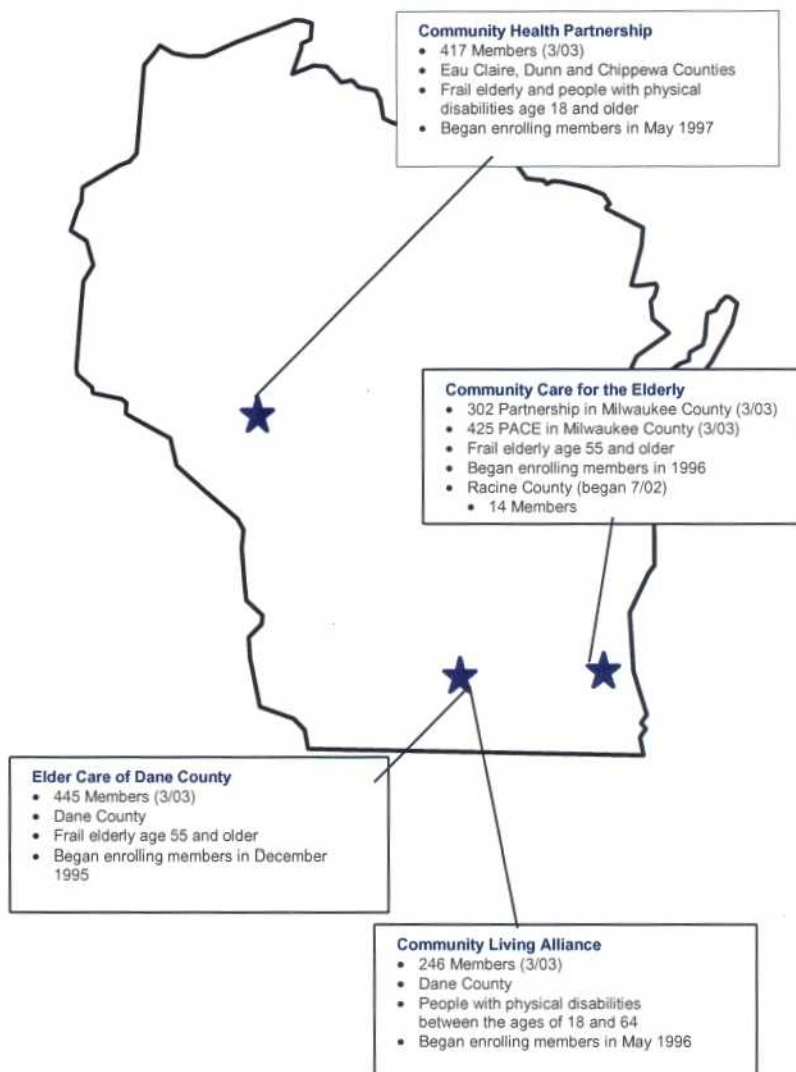
- ♦ **Integrated Health and Long-Term Care**
- ♦ **Improved Access to Community Care**
- ♦ **Increased Consumer Responsiveness**
- ♦ **Efficient Use of Resources**
- ♦ **Improved Quality and Outcomes**

### PROGRAM CHARACTERISTICS

Serving **People with Physical Disabilities** and the **Frail Elderly**

- ♦ **One Stop Shopping** – Members access all health and long-term care services through a single local provider.
- ♦ **Collaborative Interdisciplinary Care Teams** – A team of medical and social services professionals, in partnership with the member, primary care physicians, their family, caregivers, and informal supports, organize all services.
- ♦ **Member-Centered Approach** - The member is at the center of the care planning process, which assists them to make and implement decisions about their own life and care.
- ♦ **Integrated Financing** – Through fully capitated Medicaid and Medicare payments, incentives to cut costs or cost shift are eliminated.
- ♦ **Managed Care that works** – *Partnership* is a managed care system that works to produce cost-efficient quality outcomes.
- ♦ **Locally Based Providers** – All services are organized and provided by locally based, non-profit organizations. Each organization has a contracted provider network.
- ♦ **Voluntary Enrollment** – Members enroll voluntarily, and can disenroll at any time.

**Nursing Home Eligible** – Members are nursing home eligible and initially wish to remain in, or return to, the community.



- ♦ Currently, 1,410 people are enrolled in four local *Partnership Program* sites.
- ♦ Each individual program is administered by a local, non-profit organization.
- ♦ The programs serve a diverse mix of members in both rural and urban settings.

## Who does Partnership Serve?

### ELIGIBILITY CRITERIA

To be eligible, a person must meet the following criteria:

#### Age

- ♦ 55 or older (elderly programs)
- ♦ 18-64 with a physical disability determination (disability programs)

#### Nursing home level of care

- ♦ Certified through the state's web-based Long Term Care Functional Screening tool as needing care at the nursing home level (ICF1, ICF2, SNF)
- ♦ People needing ISN level of care are not eligible to enroll, but may remain enrolled if they are members and subsequently need ISN level of care

#### Financial

- ♦ Financially eligible for Medicaid or a Medicaid waiver program

#### Residential requirement

- ♦ Be a resident of a county with a Partnership Program

*Members in the Partnership Program must be Medicaid-eligible or dually eligible for Medicaid and Medicare and must also meet a nursing home level of care requirement. Enrollment and participation in the Partnership Program is voluntary, and members may disenroll at any time.*

*The Partnership Program is well suited to serve the needs of members with complex medical and social care needs requiring coordination of service across settings and over time.*

*Partnership Program members often present a combination of conditions including mental health issues, multiple diagnoses, degenerative disabilities, and chronic health conditions such as diabetes and heart and lung diseases.*

### MEMBER CHARACTERISTICS

#### Elderly

- ♦ Average age is almost 78, 32% are 85 and older.
- ♦ 72% female, 28% male
- ♦ Members each have an average of 12 medical diagnoses

#### People with Physical Disabilities

- ♦ Average age of 47.3
- ♦ 61% female, 39% male
- ♦ Members each have an average of 12 medical diagnoses
- ♦ 42 % of members have a diagnosed mental health and/or substance abuse problem (CLA)
- ♦ Only 46 % of members have "typical" physical disabilities such as spinal cord injuries (CLA)

## Why the Partnership Program?

The fragmented world of health care is difficult to manage and is most often not coordinated with long-term care services. For many elderly and people with physical disabilities, lining up services, making and keeping appointments with physicians and specialists, monitoring their own health needs and managing a myriad of bills and funding sources can be difficult and time consuming. It can take over their lives. The enormity of it can diminish the quality of their lives, and they may still be falling short of having their health and long-term care needs met.

The Partnership Program's ability to close the gaps of fragmented systems by integrating services has several advantages. Not only does Partnership manage a comprehensive array of services, it is cost effective. Partnership directly involves each person in decisions about their care. Partnership also provides a higher level of personal attention and care resulting in more consistent quality and satisfaction. With medical and social services combined into one plan, Partnership members get comprehensive, more individualized care through a responsive, more efficient, manageable system. The Partnership Program has built this powerful "one-stop shopping" infrastructure by forging new relationships among consumers, providers and funding sources.

# Wisconsin Partnership Program

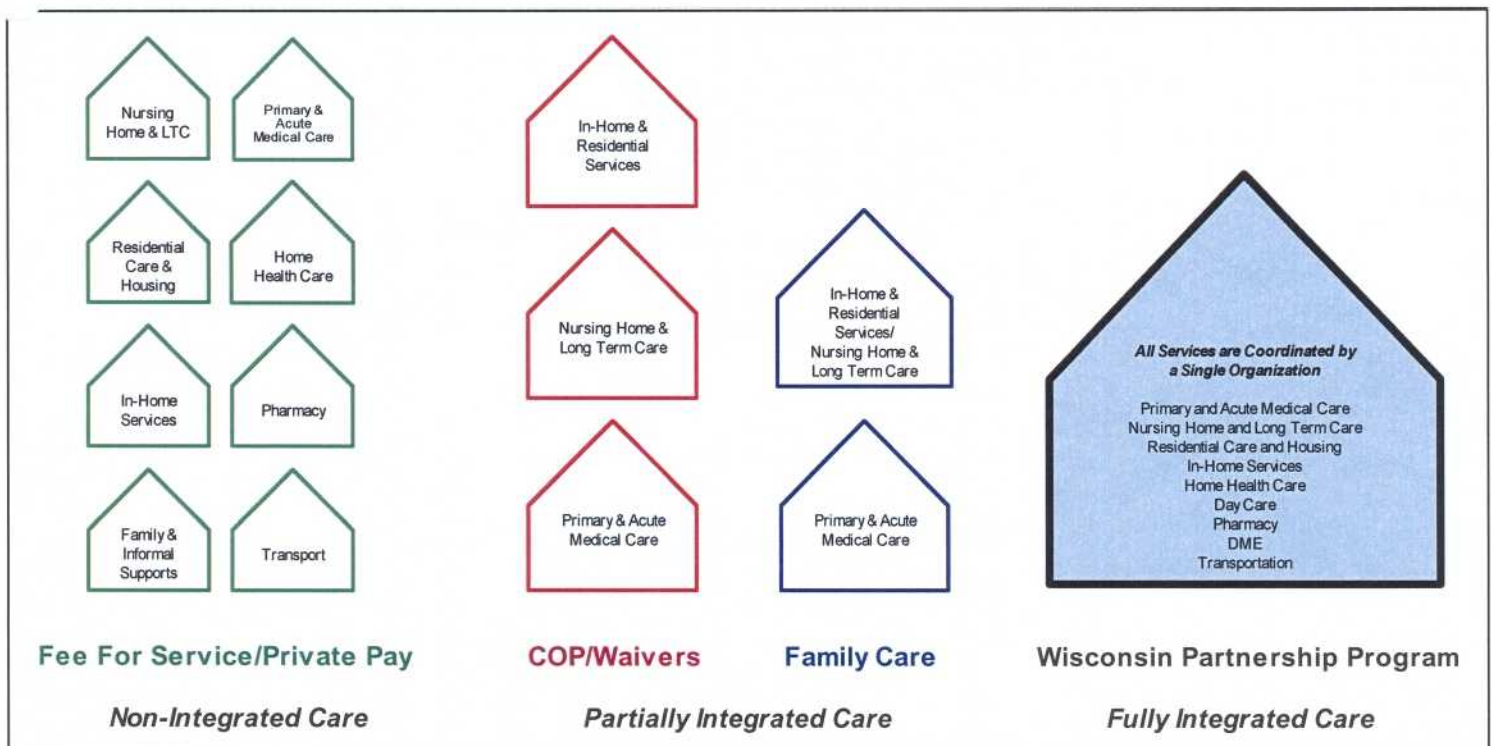
## How Does the Program Work?

The total package of services offered by the Partnership Program is unmatched by any other program in Wisconsin. This program offers an opportunity for this targeted population to remain independent. At the heart of the Partnership Program is the Interdisciplinary Team comprised of both health and long-term care professionals, working together with each person to make certain that they are getting the right services to meet their needs in a timely and organized way. The program offers:

- *Help Managing the System.* The Partnership Team understands the complex health care delivery system and acts as a guide and an advocate for the consumer in ways to manage and enhance delivery of services. The Team helps integrate the two worlds of health care and long-term care services.
- *Early Prevention & Intervention.* The Partnership Team is responsive and can take early action to meet the total needs of the member, providing better health care for the consumer
- *Voice in Decisions.* The Partnership member shares in the decision-making process with the Partnership Team to achieve the best overall treatment and support.
- *Flexible, Blended Funding.* Partnership organizations are paid directly by Medicaid, or Medicaid and Medicare, which allows the program maximum flexibility in purchasing and organizing services to meet all the health and long-term needs of their members.

## How does the program work? – one-stop shopping

As a fully integrated model, the Partnership Program provides and coordinates all health and long-term care services under one roof. In non-integrated or partially integrated programs, people have to access care from a variety of organizations and providers.



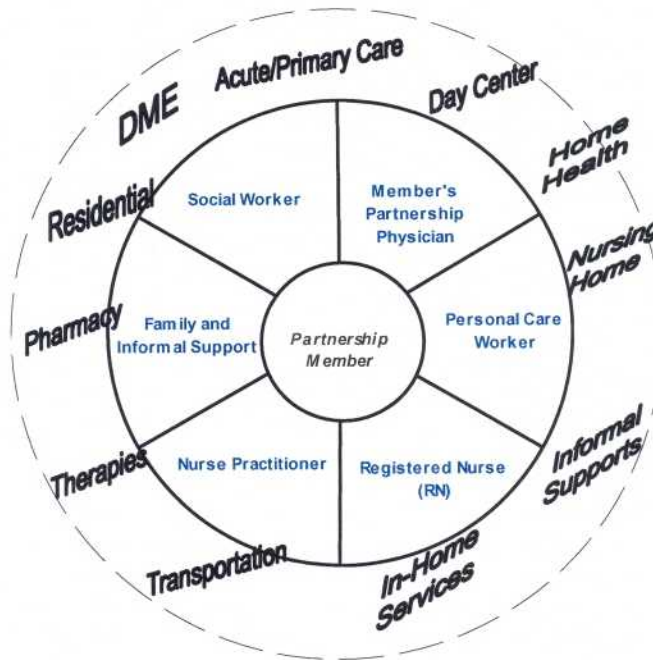
## How Does the Program Work? -- interdisciplinary team

### A MEMBER-CENTERED PLAN USING AN *INTERDISCIPLINARY TEAM MODEL*

Care management in the *Partnership Program* is team-based.

- ◆ The interdisciplinary team consists of the member, his/her physician, a registered nurse, a nurse practitioner and a social services coordinator or social worker.
- ◆ The team collaborates on the development of a care plan and coordinates all service delivery.
- ◆ The team is responsible and accountable for decisions about how expenditures are made and outcomes achieved.

Nurses and social workers are co-located in order to maximize opportunities for interactions between the disciplines.



### COMPREHENSIVE SERVICES

The *Partnership Program* wraps Medicare, Medicaid, and Home and Community-Based Waiver Programs together in a single health plan, with coordinated coverage for everything from day-to-day clinic visits and home health care to hospital and nursing home.

Covered services include:

- ◆ Hospital
- ◆ Primary medical care
- ◆ Medical specialty care
- ◆ Medications
- ◆ Nursing
- ◆ Homemaker
- ◆ Chore
- ◆ Home repair
- ◆ Home modification
- ◆ Transportation
- ◆ Meals
- ◆ Personal care
- ◆ Occupational therapy
- ◆ Speech therapy
- ◆ Counseling
- ◆ Nursing Home
- ◆ CBRF
- ◆ Day care

## What is the Need for the Program?

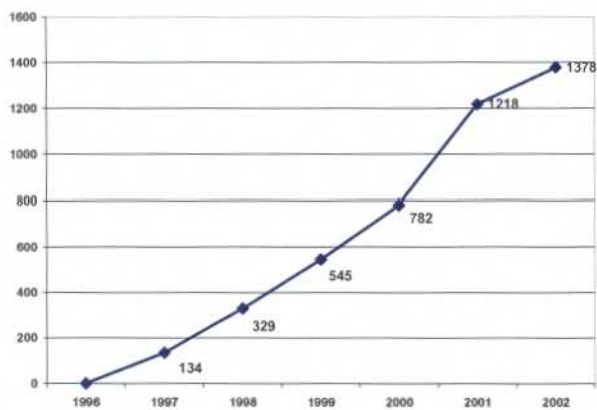
### A GROWING POPULATION OF ELIGIBLES

#### Elderly

- ◆ The elderly population in need of publicly funded care is growing at a rate of about 1,100 persons per year.
- ◆ The number of persons served by Wisconsin's long-term care programs has grown an average of 900 per year.
- ◆ The numbers of persons on the waiting lists for Wisconsin's long-term care programs is growing an average of 1,000 persons per year.
- ◆ Occupancy rates in nursing homes have declined an average of 1% per year in the past decade, leaving vacant about 8,000 beds.

Source: Wisconsin Department of Health and Family Services, Bureau on Aging and Long Term Care Resources, 3/01

Wisconsin Partnership Program  
Census Growth by Program Year



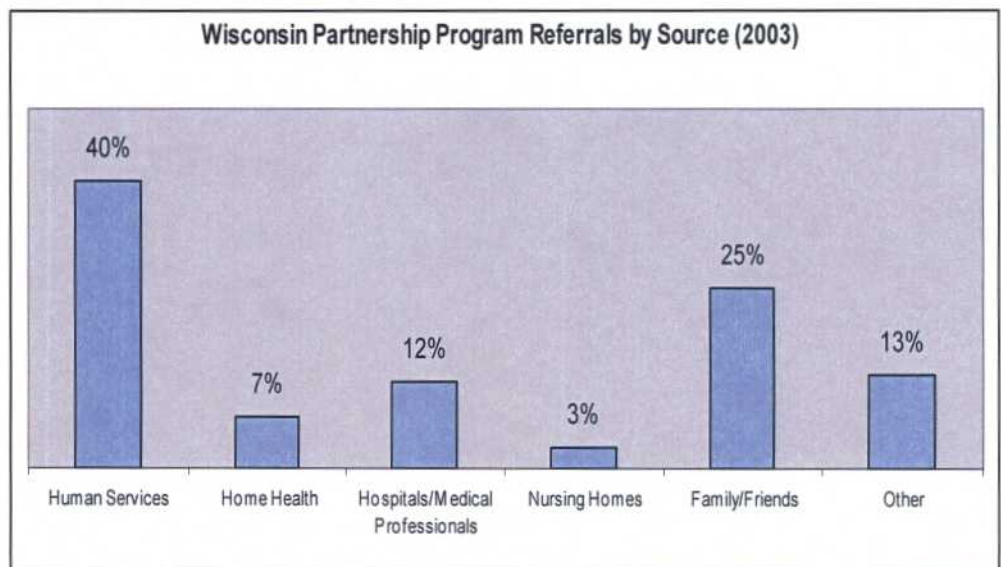
### GROWTH OF THE PROGRAM

Since its inception in 1996, the *Partnership Program* has enjoyed a steady growth in enrollment to its current level of 1,410 members

### HOW MEMBERS ARE REFERRED TO *PARTNERSHIP*

- ◆ The *Partnership Program* is seen as an important resource by the broad spectrum of individuals and organization that make referrals.
- ◆ The *Partnership Program* has been particularly effective in meeting the needs of individuals on waiting lists for other long term care programs.

Wisconsin Partnership Program Referrals by Source (2003)



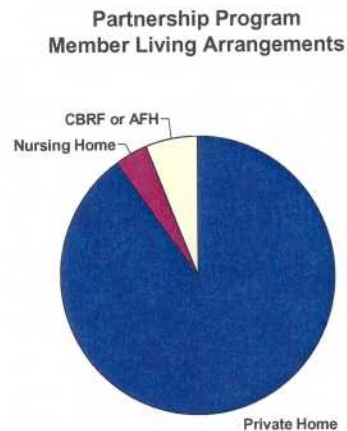
## What are the Results of the Program?

### ACHIEVE CONSUMER GOALS

Members are offered a choice of care, choice of setting and choice of the manner in which services are received. Members are supported in their choice to receive community-based care in their homes.

- ◆ The majority of *Partnership Program* members live in the community:

86% private home  
5% nursing home  
9% Community Based Residential Facility (CBRF) or Adult Family Home (AFH)



### EFFICIENT USE OF RESOURCES

For Medicaid, the Wisconsin Department of Health and Family Services (DHFS) pays a per-member, per-month rate to the Partnership programs that is based on a discounted Medicaid fee for service (FFS) equivalent. To determine the Medicaid FFS equivalent, the DHFS looks at prior year FFS costs for a population that is actuarially equivalent to the members enrolled in the Partnership Program.

For Medicare, the federal Centers for Medicare and Medicaid (CMS) pays a per-member, per-month rate to the Partnership sites that is equal to the Medicare +Choice rate times a factor to adjust for the age, frailty and disabilities of the members.

### FINANCIAL ADVANTAGES

The Partnership Program improves the quality of health care and service delivery while containing costs. Here's why:

- *Greater Efficiency.* By reducing the inappropriate use of expensive services like emergency room, hospitals and nursing home, the Partnership Program is cost-effective. The more personalized Team approach provides better understanding of each consumer's needs and reduces fragmentation and inefficiency in existing health care delivery systems. This results in better, more efficient treatment and cuts overall costs.
- *Predictable Costs to the State.* Because the State has established a capitated rate, any costs above that are covered by the Partnership Programs. In other words, the Partnership Program assumes all risk for the cost of care, not the State.
- *Program is Already up and Running.* Wisconsin has invested resources in the development and growth of the Partnership Program over the past five years. Not only has it achieved success, but it can be expanded or replicated in other Wisconsin communities for relatively low cost.

## Who are the Partnership Providers?

### Community Living Alliance (CLA)

CLA is a community-based non-profit organization located in Madison that serves adults with significant physical disabilities who reside in Dane County. CLA's background is an Independent Living Center, and, as such, fosters the independence of members, seeking their participation in the governance of the organization. CLA was selected as a Partnership site in October 1994 and began to enroll members in May 1996. There are currently 246 members. CLA has seven interdisciplinary teams in place to serve their members.

### Elder Care of Dane County, Inc. (Elder Care)

In December 1995, Elder Care became the first agency to begin enrolling members into the Partnership Program. Elder Care has been a community-based provider of long term care services in Dane County since 1976. Elder Care began providing integrated health and long-term care services in 1994 as a PACE (Program of All-Inclusive Care for the Elderly) provider. Elder Care has served nearly 700 eligible older adults over the past five years and, currently, there are 445 members enrolled in the Partnership Program. Elder Care has ten interdisciplinary teams serving Dane County.

### Community Care for the Elderly (CCE)

In 1990, CCE, located in Milwaukee, was the first agency in Wisconsin to provide an integrated model of community-based, health and long-term care for older adults through its PACE (Program for All Inclusive Care for the Elderly) program. CCE has four PACE teams serving 425 members. CCE began serving members in the Partnership Program in 1996 and currently has enrolled 302 frail older adults living in Milwaukee community. CCE has four interdisciplinary Partnership teams in Milwaukee County localized where member enrollment is concentrated. One of CCE's teams is located at a HUD housing unit for the elderly, and another team is co-located within a local hospital where CCE has developed a specialized dementia adult daycare program. CCE is currently working with county officials and local providers to expand its services into Racine County.

### Community Health Partnership, Inc. (CHP)

CHP is the only Partnership Organization to serve both target populations. It is also serving them in a rural setting. CHP began serving members in 1997 and currently has eight teams that serve 417 members (293 frail/elderly and 124 persons with physical disabilities). CHP's office is located in Eau Claire with a branch office in Menomonie. Referrals have largely come from county human service departments, as well as from hospital discharge planners, physicians, and families of members. CHP's provider network consists of the three major physician/clinic systems in its service area and a full range of other health and long-term care service providers.

# Wisconsin Partnership Program

## PARTNERSHIP PROGRAMS

If you would like to learn more about the *Partnership Program*, please call any of the following programs:

### COMMUNITY CARE FOR THE ELDERLY

1555 South Layton Blvd.  
Milwaukee, WI 53215  
(414) 385-6600

2000 Domanik Drive  
Racine, WI 53404  
(262) 633-0500

### COMMUNITY HEALTH PARTNERSHIP, INC.

2240 East Ridge Center  
Eau Claire, WI 54701  
(715) 838-2900  
(800) 242-1814

### COMMUNITY LIVING ALLIANCE

1310 Mendota Street  
Madison, WI 53714  
(608) 242-8335

### ELDER CARE OF DANE COUNTY, INC.

2802 International Lane  
Madison, WI 53704  
(608) 240-0020

Or

Steve Landkamer, Program Manager  
Wisconsin Department of Health and Family Services  
Office of Strategic Finance  
Center for Delivery Systems Development  
(608) 261-7811

